

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-016073

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 217 Primary Registration District No. 5787 Registrar's No. 33

VS 300
Rev. 4/59

1 0670

2 0670

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12 90-0

13 1-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PERIOD OF LEAD APR 17 1962		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Mississippi		a. STATE Missouri b. COUNTY Mississippi	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Charleston		c. CITY OR TOWN Charleston	
Length of stay in 1b 36 yrs.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Route 1		d. STREET ADDRESS (If outside, give location) Route 1, Box 47	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katie Tucker			4. DATE OF DEATH Month Day Year April 3, 1962
5. SEX Female	6. COLOR OR RACE Colored	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/28/1903
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sarah, Miss.
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME John Hargrove	
13b. MOTHER'S MAIDEN NAME Mary Porter		14. NAME OF HUSBAND OR WIFE Jake Tucker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT Address Mo. Dorothy Armstrong, R. 1, Box 47, Charleston
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cerebral Vascular Disease w R			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arterio Sclerosis ?			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
21. I attended the deceased from <u>3-15-62</u> to <u>3-30-62</u> and last saw her alive on <u>3-30-62</u>			
Death occurred at <u>11:05</u> A. m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <u>510 South Main Charleston Mo.</u>	22c. DATE SIGNED <u>4-3-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 8, 1962	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery	23d. LOCATION (City, town, or county) (State) Charleston, Missouri
24. FUNERAL DIRECTOR L. R. Sparks ADDRESS Charleston, Mo.		25. DATE RECD. BY LOCAL REG. 4-3-62	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

AUG 30 1962

Permit received
4-3-62
-284

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James A Carter

Licensed Embalmer No. 44681

P. O. Address Osborne, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.